
Executive summary

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This report looks different from MedPAC's two previous reports to the Congress on payment policy. It begins to move toward work that integrates discussions of payment, access, and quality, and highlights the key policy issues Medicare faces in paying for the range of care that beneficiaries receive. The report summarizes what we know about where the Medicare program is headed and presents MedPAC's views on a variety of issues, whether as recommendations or as work in progress. We will make additional payment recommendations in our June report on the financial condition of hospitals.

Recent changes in the Medicare program

The Balanced Budget Act of 1997 (BBA) enacted the most far-reaching changes to the program since its inception, including reducing payment updates, instituting new prospective payment systems, adding benefits for preventive care, and allowing new types of private health plans to participate in Medicare. In response to concerns that the BBA had reduced spending too much, the Congress enacted the Balanced Budget Refinement Act (BBRA) in the fall of 1999. That law eased or delayed selected BBA provisions, thus increasing payments for many providers.

Because the BBRA has not been fully implemented, its impact cannot yet be assessed. Even for the BBA, analysis is constrained by a limited amount of data; an inability to tease out cause and effect given multiple, simultaneous policy and market changes; and the extended phase-in schedules of many policies. In addition, measuring beneficiaries' access to care—a critical indicator of the success of the program—is an imprecise science.

Any evaluation of the BBA's impact must attempt to balance Medicare's multiple roles and responsibilities. For example, although Medicare has a responsibility to ensure that beneficiaries have access to quality care, it must also be a prudent purchaser—paying a fair market price for the goods and services it buys. Medicare should not allow fraud and abuse or be expected to compensate providers for lost income from other payers. Lower-than-expected spending and poor provider financial performance, in and of themselves, do not indicate that the BBA missed its mark.

Ultimately, MedPAC is concerned about how the BBA and other policy changes affect beneficiaries' access to care. Are providers willing to care for them? Is the care they receive appropriate? Is the health care infrastructure sufficient to meet the needs of Medicare beneficiaries? The Commission has found no increase in systemic access problems, but is concerned that previous barriers for vulnerable populations persist.

Medicare beneficiaries' access to quality health care

The BBA altered Medicare's payment policies in ways that could affect beneficiaries' access to quality care, such as by decreasing providers' willingness to serve them or by causing providers to reduce the value of the services they provide. Shifts to prospective payment for providers that were previously reimbursed on a cost basis could change the availability of certain services by altering incentives for providing them. Changes in payments to Medicare+Choice plans could reduce access to services for enrollees and reduce the extent to which plans offer additional benefits.

MedPAC believes there is little evidence that policy changes enacted in the BBA have harmed beneficiaries' access to care, but concludes that additional attention is warranted in some areas. The Commission's analysis of data from surveys of Medicare beneficiaries and our survey of physicians shows no increasing access problems, but there is some evidence that patients with greater needs may face difficulty in obtaining some types of post-acute care.

In a time of ongoing change in Medicare policies, continued close monitoring of access to care is essential. A focused effort to identify emerging access issues and evaluate the nature and scope of access problems is in order. Accordingly, the Commission recommends that the Secretary report annually to the Congress on findings from studies undertaken to examine potential problems in beneficiaries' access to care.

Revising payment methods and monitoring quality of care in traditional Medicare

In its traditional fee-for-service program, Medicare uses separate payment systems to compensate each type of provider for furnishing covered services. Some of these systems, such as those for hospital inpatient care and physicians' services, are well-established prospective payment systems (PPSs). Others, such as those for ambulatory care services and most post-acute care services, are being fundamentally changed in response to the BBA, which required the Health Care Financing Administration (HCFA) to replace its cost-based reimbursement methods with new PPSs.

To ensure that Medicare beneficiaries have access to necessary care in appropriate settings, both existing and new PPSs must yield payment rates that approximate the costs efficient providers would incur in furnishing high-quality care. Meeting this goal under varied market conditions in many different health care settings is a complex challenge because Medicare pays for thousands of covered products and services furnished by a multitude of providers—physicians and other health care professionals, hospitals and other facilities, and suppliers—in hundreds of markets nationwide. In carrying out our mandate to examine Medicare's payment policies, MedPAC has developed an analytic framework that guides our assessment of the changes under way, whether they involve refinements or significant rethinking.

MedPAC's framework for considering payment policy is structured around five major design elements common to all administered pricing systems:

- **the unit of payment**, which governs providers' ability to economize on the mix and quantity of services and other inputs needed to produce the unit;
- **product classification systems** and **relative weights**, which define distinct services or products expected to require different amounts of resources to produce and their expected relative costliness;
- **adjustments to payment rates**, which allow policymakers to account for differences in providers' circumstances, such as geographic variation in input prices or in the type of care delivered;
- **initial payment levels**, the base payment rates established when a new payment system is implemented; and
- **payment updates**, which account for changes over time in the efficient level of costs needed to produce a product or service.

In Chapter 3, we discuss the first three elements, which determine the distribution of payments among specific services and providers, and make recommendations as they apply to post-acute care, hospital inpatient services, and physicians' services. (MedPAC made recommendations with respect to the new payment system for hospital outpatient services in our March 1999 report and will revisit those recommendations when pending refinements by HCFA are announced.) In Chapter 4, we discuss the last two elements, which govern the amount of money in the payment system.

Rethinking payment for post-acute care

Payment systems for virtually all post-acute care providers are changing from cost-based to prospective payment in response to mandates in the BBA and the BBRA. Payment for care in skilled nursing facilities (SNFs) has been prospective since July 1, 1998, and payment for both home health and inpatient rehabilitation services will be made prospectively beginning October 1, 2000. Payment for outpatient therapy services has been made on the basis of the physician fee schedule since January 1, 1999. These changes raise two issues: whether the design elements of the new payment systems are appropriate and how policymakers can best monitor their impacts on the quality of post-acute care.

Over the next year, home health agencies will face the biggest change in payment policy as HCFA implements a PPS for home health services. The unit of payment under the proposed system is a 60-day episode of care, with Medicare's payment intended to cover all home health goods and services (other than durable medical equipment) once a low-use threshold has been crossed. The PPS will classify patients using Home Health Resource Groups that assign patients to one of 80 different groups, with relative payment rates for each group reflecting different severity levels and needs for care. The labor-related component of payments will be adjusted for variation in local wages.

MedPAC generally supports the agency's approach and believes the new system should be carried out as scheduled. In the short run, the Secretary should use data that home health agencies have been submitting since August 1999 to refine the system's case-mix adjustment and stabilize rates for the smallest case-mix classification groups. Once the PPS is implemented, the Secretary should vigorously monitor home health agency behavior to detect attempts to manipulate the new payment system. Over the long run, MedPAC believes the Congress should modify the PPS to blend fixed-episode payments and per-visit payments. Such a blended system could counteract some of the incentives to stint on care that would exist under a pure episode-based system.

Under the PPS for skilled nursing facilities, SNFs are paid a case-mix adjusted per diem rate for each patient, which is intended to cover all routine, ancillary, and capital costs. Patients are assigned to one of 26 different groups using the Resource Utilization Group, Version III (RUG-III) classification system. The RUG-III classification system reflects treatment costs that are correlated with staff time, but not the use of ancillary services, raising concerns that the PPS underpays for patients who require both therapy and nontherapy ancillary services. In response to these concerns, the Congress increased payments for 12 RUGs covering medically complex cases and three select rehabilitation RUGs. MedPAC believes these increases are only temporary measures and do not solve the underlying problems inherent in the classification system. HCFA is currently studying revisions to the system.

In our March 1999 report, MedPAC recommended that the PPS for inpatient rehabilitation services be discharge based and use the Functional Independence Measure-Functional Related Groups classification system. The Congress enacted this recommendation into law in the BBRA, and HCFA is expected to issue an implementing regulation this spring. MedPAC will revisit this issue when the regulation is issued.

Monitoring the quality of post-acute care

The move to prospective payment—in progress or planning stages for most post-acute care services—provides a strong motive to create systems for monitoring the quality of care beneficiaries obtain. Payment systems designed to reward efficiency could cause quality problems if providers adopt cost-containment strategies that inappropriately reduce the intensity, duration, or skill level of the services they furnish. If payment levels

are set too low—either overall or for certain types of patients—access problems could result.

At present, Medicare’s ability to monitor the quality of care in post-acute settings is limited, although HCFA has taken a number of steps to generate information on the quality of care furnished by certain types of post-acute care providers. MedPAC supports the intent of HCFA’s efforts, but recommends enhancing or redirecting them by developing quality monitoring systems for all types of post-acute care providers, coordinating these systems across providers, and using both common core measures and additional measures as needed in particular settings. Finally, the Commission recommends that the Secretary take steps to increase the utility of patient assessment data now being collected while reducing the burden on providers and beneficiaries.

Refining payments for inpatient care in prospective payment system hospitals

The main features of the prospective payment system that Medicare uses to pay for inpatient hospital care have remained remarkably stable for almost two decades. MedPAC’s current work focuses on policy issues related to four components of the payment system:

- whether Medicare should continue to make separate operating and capital payments,
- whether Medicare could improve the accuracy of its PPS payments,
- whether Medicare’s expanded transfer policy is appropriate, and
- how Medicare can improve its payments to providers who serve a disproportionate share (DSH) of low-income patients.

MedPAC recommends that the Congress combine operating and capital payment rates for hospital inpatient care. Such a change would simplify the hospital PPS, reduce the costs and complications of maintaining it, and clarify incentives facing hospitals. Combining payments would have no impact on aggregate payments, and payments would change minimally for major classes of hospitals.

In MedPAC’s August 1999 report to the Congress on payment policies for graduate medical education, the Commission promised to examine refinements to the inpatient PPS to improve payment accuracy and better capture differences in the severity of cases. MedPAC is evaluating three potential refinements in Medicare’s policies: changing the diagnosis related groups (DRG) patient classification system, altering the current methods of calculating the DRG relative weights, and changing how outlier payments are financed. This report presents preliminary findings from that evaluation.

Medicare’s transfer policy was initially intended to recognize that hospitals discharging patients to another hospital did not necessarily provide the full course of care implied by a full DRG payment. The BBA expanded the transfer policy beginning in fiscal year 1999 to cover discharges to post-acute care providers in 10 DRGs. MedPAC supports the concept underlying the expanded transfer policy, but believes its impact should be more fully understood before it is expanded to all DRGs.

Medicare’s DSH payments are intended to protect beneficiaries’ access to care in hospitals whose viability might otherwise be threatened by providing care to the poor. These payments are now made on the basis of a complex formula that measures care to the poor through the share of patient days accounted for by Medicaid enrollees and Supplemental Security Income recipients. As we have previously, MedPAC recommends changing the formula to include the costs of all poor patients. We also recommend making 60 percent of hospitals eligible for DSH payments.

Improving payment for physicians' services

The physician payment issues addressed in this report relate to how services are classified for payment under the physician fee schedule. To promote accuracy in payments, HCFA has taken two steps. It has established documentation guidelines for an important group of services—evaluation and management services—and has required its contractors to use a set of established standards, called coding edits, to look for inconsistencies in code assignments. Because both of these steps have raised concerns among the medical community, MedPAC recommends that HCFA continue to work with physicians in developing and implementing them.

Updating payment rates in traditional Medicare

To ensure that Medicare beneficiaries have access to care in an appropriate setting and to give providers incentives to supply that care efficiently, Medicare's base payment rates must account for variations in the prices of inputs that providers face, the mix of patients they see, or the particular bundle of services they provide. These base payments must also be updated over time; how that is done depends on policymakers' objectives. One possible objective is to maintain consistency with efficient providers' costs; another is to control program spending.

Medicare currently uses two different approaches to updating payments. One approach—used to update payments for inpatient hospital services—involves projecting factors expected to affect providers' costs in the coming year. The other approach—used to update physicians' fees—takes into account some of these factors, but provides for updates only when changes in program spending are consistent with an expenditure target.

As Medicare continues to implement PPSs for new categories of services, policymakers will need to make explicit update decisions that were once made implicitly. Payments previously determined on the basis of cost-based reimbursement—including payments for services provided by skilled nursing facilities, home health agencies, hospital outpatient departments, and rehabilitation hospitals—generally rose automatically as providers' costs increased. Under PPSs, payment rates will increase only when policymakers choose to increase them.

For settings where no expenditure target is in place, MedPAC has developed a general framework that accounts for the likely impact of three sets of factors on patient care costs. These factors include changes in the price of inputs, changes in the inputs used and the product or service produced, and changes in case mix. MedPAC has used this framework in the past to recommend updates for inpatient hospital services and will do so again in June when we report on hospitals' financial condition. The Commission is also developing the details of this framework as it applies to skilled nursing facilities.

Two factors make updating payments for ambulatory care challenging. First, these services may be provided in several different settings: hospital outpatient departments, ambulatory surgical centers, and physicians' offices. Other things being equal, Medicare should pay similarly for services, irrespective of the setting. Second, the Congress has already established an expenditure target for physicians' services and has directed HCFA to develop a method for controlling unnecessary increases in the use of hospital outpatient services. The agency has proposed an expenditure target as one way to fulfill that requirement.

Last year, concern about update consistency among ambulatory care settings prompted MedPAC to recommend a single mechanism that would link payment updates for these settings. However, based on further analysis and consideration, MedPAC has concluded that although consistency in updates is conceptually desirable, complex issues must be resolved before that goal can be achieved. Accordingly, the Commission recommends

that Congress not establish a single expenditure target to determine payment updates for physicians' services and ambulatory care facilities. Further, the Commission recommends that the Secretary not establish setting-specific expenditure targets.

Medicare+Choice: trends since the Balanced Budget Act

The Congress had two explicit goals when it created the Medicare+Choice (M+C) program: to provide beneficiaries with greater choice in plan options and to help control the growth in Medicare spending. M+C was also important to members of the Congress who saw it as a way to provide Medicare beneficiaries with benefit packages richer than the traditional Medicare fee-for-service package, particularly with respect to coverage of outpatient prescription drugs.

Progress toward these goals has been halting. The rate of increase in program payments per beneficiary enrolled in M+C has slowed since enactment of the BBA, but the availability of plan options has not increased: most beneficiaries in rural areas still cannot enroll in M+C plans, benefit packages have become less generous, and enrollment growth in M+C plans has slowed.

Achieving all of the Congress's goals simultaneously has been difficult because they are partially at odds. For example, there is a basic conflict between the goals of controlling Medicare spending and providing richer benefits for beneficiaries. Slower payment growth has coincided with continuing rapid increases in the cost of outpatient prescription drugs. But factors other than payment rates have also contributed to the lack of progress. Some obstacles relate to data collection and quality improvement requirements enacted in the BBA that are more difficult for some plans to meet than for others. Other obstacles reflect fundamental market conditions. For example, the low population density and presence of few providers in many rural areas make it difficult for plans to form networks. Finally, the environment in the post-BBA world has been more uncertain than in the recent past. This uncertainty makes it difficult for plans to justify entering the program or new areas.

In the BBRA, the Congress undertook several steps to help the M+C program make progress toward the goal of expanding plan participation. First, it raised future payments to plans by increasing the update, delaying the phase-in of risk adjustment (which will reduce payment rates when fully implemented), and reducing the assessment for beneficiary education. Second, the Congress codified two regulatory provisions that HCFA had been following but which were not in law. One moves the deadline for plans to submit their applications for inclusion in M+C from May 1 to July 1. The other allows plans to segment their service areas along county lines and thus better match revenues to costs. Third, the BBRA established bonus payments to plans that enter areas where no other M+C plan is operating, a move intended to foster participation in rural areas. Finally, the act reduced requirements of the M+C quality assurance program for preferred provider organizations.

MedPAC believes that these congressional actions have the potential to succeed in providing Medicare beneficiaries with more coverage choices. The Commission supports the general thrust of the M+C provisions in the BBRA and will continue to monitor the program's progress toward its goals.

Improving payment for end-stage renal disease services

MedPAC has examined the current system of paying for the care of patients with end-stage renal disease (ESRD) to ask whether it meets Medicare's payment policy objectives. These objectives include controlling costs; providing cost-effective, quality care to patients using the most suitable modality in the most suitable setting; and promoting access to services.

Under current law, patients with ESRD are prohibited from participating in the M+C program unless they were already enrolled before they developed ESRD. This prohibition reflects concerns that limitations in the current payment system make it inconsistent with providing high-quality care to enrollees with ESRD. MedPAC recommends that the Secretary risk-adjust payments for patients with ESRD enrolled in Medicare+Choice. Once a risk-adjusted payment system has been implemented—together with a system to monitor and report on the quality of care—the Congress should lift the prohibition. In the meantime, MedPAC also recommends that ESRD patients who lose M+C coverage because their plan leaves the area should be permitted to enroll in another plan.

In the traditional Medicare program, MedPAC recommends increasing the composite rate for outpatient dialysis services. The Commission also recommends that the Congress require HCFA to review the composite rate payment annually.